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wound in the neck of the said infant plaintiff from dislodging and entering the neck. . ."

The case was tried before Mr. Justice Whittaker of the Supreme Court of British Columbia on March 1 and 2, 1955, and judgment was reserved. On May 10, 1955, the action against the doctor was dismissed. The following were the reasons for judgment:

The evidence leads me to the conclusion that the rubber drain was released from the clip when the bandage which had been applied by the defendant was torn away by the infant plaintiff, or by the child plucking at the protruding end of the drain after he had torn the bandage off. Even if it could be said that *res ipsa loquitur* applies, and I think it cannot, the evidence of the defendant and of other witnesses satisfies me that there was no negligence on the part of the defendant, in the method used to affix the drain in the first instance, or in failing to discover that the drain had become lodged in the wound; nor do I think the defendant can be held accountable for the failure to use more effective methods of preventing the child from reaching the bandage with his hands.

The first specific act of negligence alleged in the statement of claim is failure, immediately following the operation, to secure the rubber drain in such a way as to prevent it from disappearing into the wound.

The edges of the wound were held together by means of Michel clips. The drain was fastened as shown in exhibit 2. One prong of the clip holding the drain penetrated both the drain and the skin. All the doctors who gave evidence say this is one of the three methods commonly used and is an acceptable and recognized procedure. Dr. N. says he does not usually secure the drain at all, relying on the mucus oozing from the wound to act as a mucilage causing the drain to adhere to the gauze of the dressing.

Dr. G. said that on his first post-operative visit at 10:30 a.m. on May 31, the bandage was on the floor and there was no sign of the rubber drain. He said the central two or three clips were loose but they were holding the skin together and it was not necessary to replace them. Presumably the drain had originally been fastened by one of the clips found by the defendant to be loose. It is difficult to see how both ends of that clip could be found holding the skin together after the drain had been torn away. A possible explanation is that the clip had been readjusted by the nurse who put on the fresh bandage earlier that morning; or the defendant may not have noticed that one end of one of the clips was not attached to the skin. In any event, I accept without question Dr. G.'s testimony that the drain was properly secured by means of a clip before the infant plaintiff was removed from the operating room.

The next specific act of negligence alleged is that the defendant failed to probe the wound before the child was discharged from the hospital, in order to ascertain whether the drain was lodged in the wound.

When the defendant paid his first post-operative visit on the morning following that of the operation he found the bandage lying on the floor. There was no sign of the rubber drain. The defendant spoke to the nurse in charge. They both consulted the chart. The chart said nothing about the drain. They consulted the notes made by the nurse who had been in attendance. Those notes disclosed that the child had torn off the dressing at 5 o'clock that morning, but there was no mention of the drain. After making all possible enquiries and examining the wound externally the defendant came to the conclusion that the drain must have come away with the dressing; that the chance that it might have gone into the wound was so remote he would not be justified in probing the wound. He came to that conclusion:

1. Because of the remoteness of the chance that the drain would become embedded in the type of wound;
2. Because of the danger of damaging tissue by probing and of introducing new infection and of activating infection already in the wound; and
3. Because he felt the presence of a foreign body in the wound would become manifest either before the child left hospital or within a period of two weeks following the operation.

These would seem, to a layman, to be very cogent reasons, and they are all supported by Dr. N., a very eminent surgeon, who says he would have done exactly as the defendant did. In addition, the plaintiff's expert witness, Dr. A., said he would not want to open the wound unless necessary.

The only other specific act of negligence alleged is that the defendant failed to take steps to see that the child was adequately restrained. The method used by the nurses was a harness which, however, did not prevent the child raising his hands to his neck. It is not for me to make a finding of negligence, unless such negligence is to be imputed to the defendant. In effect, the evidence is that complete restraint, as by tying the child's hands to the sides of the crib, is apt to have a bad effect on the patient, and is to be used only when necessary. The necessity for such restraint can be judged only by those who have, or ought to have, the patient under their constant observation and care following the operation. For them, the exercise of such judgment, and the use of such methods as the occasion may seem to require, are matters of routine. It is not necessary for the operating surgeon to issue specific instructions. Dr. N. was asked:

Q. "What is your practice with respect to restraining a child two years old that has undergone an operation of that nature?"

A. "There are no standing orders for it, sir. That's more or less the responsibility of the trained nurses we have there for the child—lots of children have operations on their neck and don't require restraint, and some must do. There is no standard procedure.'

Q. "Does the doctor give instruction to the nurses about that?"

A. "No, he is not of necessity there when the restraint becomes necessary."

In these days of busy surgeons and up-to-date hospitals that would appear to be only common sense.

The action must be dismissed.

Association Notes

REUNION A QUEBEC

LA VILLE DE QUÉBEC se réjouit á la pensée d'accueillir dans ses murs le prochain Congrès de l'Association Médicale Canadienne.

Fait ignoré par plusieurs c'est à Québec, que fut fondé, en 1867, l'Association Médicale Canadienne. Le prochain Congrès prend donc un peu l'aspect d'un pélerinage au pays natal.

Depuis plusieurs mois, les différents comités sont à l'œuvre pour l'élaboration d'un programme scientifique digne des précédentes réunions annuelles.

Nous voyons dans ce Congrès l'occasion d'échanges scientifiques et culturels d'une portée considérable.

Nul doute que tous nos confrères de langue française partagerons cet enthousiasme.

Une nombreuse assistance est prévue et tous les médecins de la Province de Québec, membre ou non de l'Association Médicale Canadienne, seront les bienvenus.

QUEBEC MEETING

THE OLD CITY OF QUEBEC, founded in 1608 by Champlain, looks forward with the greatest pleasure to the annual meeting of the Canadian Medical Association to be held next June within its walls – walls which have witnessed so many other memorable events.

It was in Quebec in 1938 that King George VI, and some years later Her Gracious Majesty Queen Elizabeth, were welcomed in Canada. During the last War, the Citadel of Quebec was chosen by Roosevelt and Churchill for one of their meetings. And finally, a fact that many are not aware of, the Canadian Medical Association was founded in Quebec, in 1867, so that the next meeting may be considered as a bit of a pilgrimage to the native land.

For several months, the different committees have been working at the elaboration of a programme worthy of previous annual meetings. The President-Elect, Dr. R. Lemieux, and the members of the Quebec Division hope that this Congress will be the occasion for a scientific and cultural exchange of great importance. They have no doubt that all members will be pleased with the choice of Quebec City for this congress. Besides the points enumerated above, everyone will find that tourist interest which has conquered the hearts of so many visitors. The Committee on Entertainment will help in visits to historic sites.

Those who would like to take their holidays at the same time can get all the necessary information from this committee.

As a large attendance is anticipated, we suggest that each one begin thinking about this important meeting now.

SCIENTIFIC EXHIBITS
Annual Meeting-C.M.A.
Quebec City, June 11-16, 1956

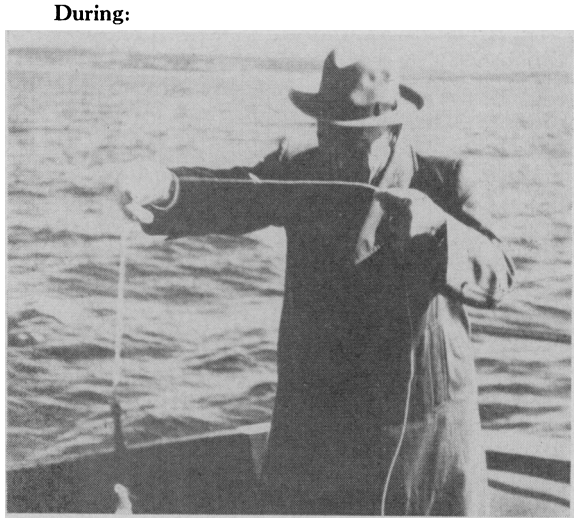
LIMITED SPACE is available for scientific exhibits. In writing for an application form, please give some details regarding the subject, type of exhibit, approximate floor and wall space required and any extra equipment required. Application should be made before March 1, 1956 to: Dr. Carlton Auger, Department of Pathology, Laval University, Quebec City, Que.

INTERLUDE IN THE PRESIDENTIAL TOUR– NEWFOUNDLAND, 1955

Drs. T. C. Routley and A. F. W. Peart are initiated into the mysteries of jigging for cod by Dr. R. J. Simms of St. John's.

Before:

During:



After:

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PRESIDENTIAL VISIT TO ENGLAND

IN THE COURSE of his duties as President of the British Medical Association, Dr. T. C. Routley attended the November meeting of the Council of the B.M.A. in London, England. He expressed himself as amazed at the amount of business that the B.M.A. Council had to get through and was very laudatory of the detailed and careful preparation for the meeting which had been done by the Secretary, Dr. Macrae, and his staff.

At the conclusion of the meeting a Council Dinner was held in the Great Hall of B.M.A. House, London, on November 4 in honour of the six eminent members of the medical profession of the Soviet Union who had that day concluded a three-week visit to the United Kingdom as guests of the B.M.A. As President of the Association, Dr. Routley received the guests, who included the Minister of Health, the President of the Royal College of Physicians, the President of the Royal Society of Medicine, the Secretary of the Medical Research Council and numerous representatives of learned societies and government departments. The Soviet visitors were: Professor S. A. Sarkisov, Director of the Scientific Brain Institute of the U.S.S.R.; Professor V. V. Kovanov, Director of the School of Operative Surgery and Topographical Anatomy of the first Moscow Order of Lenin Medical Institute; Professor G. F. Gause, Deputy Director of the Institute of Research for New Antibiotics; Professor L. F. Larionov, Director of a department of the Institute of Experimental Pathology and Therapeutics of Cancer; Professor M. N. Foteeva, Director of the Biophysical Laboratory of the Institute of Therapy; Dr. L. G. Bogomolova, Director of the Laboratory of Blood Transfusion, Leningrad Institute.

They had for three weeks been making an intensive study of medical organizations in London, Oxford, Cambridge, Edinburgh, Glasgow and Birmingham, and had exchanged experiences with their British colleagues in many fields of medical science. They had, in addition, been given the opportunity to visit various historical and cultural institutions in Britain. At the conclusion of the dinner the Russian delegation was given a film illustrating corneal grafting, from the B.M.A. Film Library, and they, in turn, presented to the Association a number of gifts, including an arterial suture machine and other surgical instruments.

AMENDMENTS TO D.V.A. SCHEDULE OF MEDICAL FEES

NEGOTIATIONS have been proceeding for several months with the Department of Veterans' Affairs with a view to achieving an upward revision of the schedule of medical fees relating to physicians' visits. The schedule was last revised in 1954 and it was the view of the Canadian Medical Association that the increases then authorized were inadequate in the light of current costs of practice.

Information has been received that, effective January 1, 1956, the Treasury Board has authorized the following schedule to apply to services rendered to entitled veterans under the doctor-of-choice plan:

(a) Office—Day Visit—$3.00.
(b) House—Day Visit—$4.00.
—Night, Sunday and Emergency—$5.50.

CANADIAN INTERN PLACEMENT SERVICE

ONE of the most useful activities of the Canadian Association of Medical Students and Interns is the operation of the Canadian Intern Placement Service. The system operates to provide an orderly and systematic method whereby the current graduates of participating Canadian medical schools may seek their initial internships in Canadian hospitals approved by the C.M.A. for the training of interns. Freedom of choice by senior medical students and freedom of choice by the participating hospitals are the essentials of the plan. As the number of approved internships greatly exceeds the current output of Canadian medical schools no system can supply all hospitals with the number of interns they desire. Despite this fundamental limitation, C.I.P.S. provides a far more equitable distribution of the available interns than any other system yet devised on a national scale.

Reporting to the Annual Conference of CAMSI, Mr. M. E. Graham, student Secretary-Treasurer of C.I.P.S., stated that 373 graduates of the class of 1955 at six participating medical schools had been placed in internship in 36 Canadian hospitals; 91% of students using the service had been placed in the hospital of their first choice, 6% in their second choice, 2.5% in their third choice and none were unplaced. It is estimated that 102 students of these medical schools sought and obtained their first internships in the United States.

At five Canadian medical schools degrees are not awarded until after the first internship and students are directed to hospital appointments in institutions affiliated with the university. The graduates of these schools do not participate in C.I.P.S.

Although the C.I.P.S. system of appointments is simple and straightforward, it depends on the co-operation of a large number of individuals. It is perhaps too much to expect that some hospital administrators will not seek their own advantage

by extracting pledges from likely applicants, thus nullifying the element of free choice, and that some students will not change their minds after assignment, thus bringing into discredit the individual and the system. These are the exceptions and it is evident that a substantial majority of hospitals and students find in C.I.P.S. a satisfactory method of arranging for the all-important first internship.

As the Service swings into action for the current academic year, students are seeking information about the training available to them in hospitals from coast to coast. Teaching hospitals naturally occupy a preferred position, but approved hospitals remote from universities can attract interns by providing supervised instruction by an interested and well-organized medical staff and adequate publicity directed towards the students.

MEDICAL SOCIETIES

COLLOQUE INTERNATIONAL ON CHLORPROMAZINE AND THE NEUROLEPTIC DRUGS

An international conference on the clinical and pharmacological aspects of chlorpromazine, reserpine and related drugs was held in Paris, France, October 20 - 22. The conference was called by the Medical Faculty of the University of Paris and was organized by the Chairman of the Department of Psychiatry, Professor Jean Delay, who is Director of the Centre Psychiatrique at St. Anne Hospital, Paris.

Representatives from 25 countries had been invited and had come to Paris, some of them from as far away as Peru and Mexico. Three representatives from the United States and three from Canada presented papers at the conference. Dr. L. Larue, Medical Director, Saint-Michel-Archange Hospital, Mastai, Que., acted as chairman at one of the sessions. The meetings were held in the lecture room of the St. Anne Psychiatric Hospital, which is about half an hour's drive by taxi from the Opera and the centrally located hotels in Paris.

The St. Anne Hospital has a long history and a fine psychiatric tradition. Its buildings are old and the lecture room was just large enough to hold the audience of about 150. A great deal of planning had gone into the organization of the meeting. Papers were to be delivered in four languages—French, English, German, Italian—and simultaneous interpretation into French and English was available not only in the conference room but also by personal portable receiver elsewhere in the building or grounds.

As there were 112 speakers on the programme and (counting the discussants) 142 different presentations were given during the three days, each paper was limited to eight minutes and the chairmen generally held the speakers strictly to the allotted time. The fast pace at which the papers were delivered and their conciseness made them sometimes difficult to follow, particularly toward the end of the day. All contributions will, however, be published in one volume and many of them in somewhat extended form.

Most of the contributions dealt with chlorpromazine, but about 20 reports considered reserpine. A few speakers made reference to new drugs with similar therapeutic effects such as Atarax and A Y 5406-1 which have not yet emerged from the experimental stages and might possibly produce serious complications (Busscher). Some time was spent on discussion of a generic name for these new therapeutic agents in psychiatry, and the term "neuroplegic drugs" was proposed by Delay and Deniker, who were the first to introduce such a drug (chlorpromazine) into psychiatry three years ago.

A few reports dealt with the mode of *administration*. While most clinicians rely on intramuscular and oral administration, hibernation methods employing cooling of the patient and the use of a mixture of drugs with effects on the central and autonomic nervous system in addition to chlorpromazine were described by some speakers (Ey *et al.;* Picard *et al.;* Neveu). Hibernation seems to be a difficult and somewhat risky procedure. Continuous intravenous perfusion with chlorpromazine in states of acute excitement was recommended as a comparatively simple and safe (Lecomte *et al.*) method of administration.

There seemed to be general agreement about the principal *indications* for chlorpromazine in psychiatry; namely, manic states; acute psychotic breakdowns associated with psychomotor excitement; anxiety and panic states; psychosomatic conditions; delirium tremens and other toxic-confusional states. Newer therapeutic applications of chlorpromazine were reported in Huntington's chorea (Walter-Buel) and in porphyria (Coulonjou).

Of particular interest were the reports on the therapeutic effectiveness of chlorpromazine and reserpine in chronic schizophrenia. There was considerable agreement that these drugs may either prevent chronicity or modify it in such a manner that social recoveries may be obtained in a good proportion (35-75%) of chronic patients (Delay and Deniker; Schneider; Racamier; Staehelin and Labhardt . . .) kept on maintenance doses of the drug after leaving the hospital. Hyvert found that his female chronic patients responded better than his male and was able to improve his therapeutic results with male patients by giving them œstrogens with the chlorpromazine. Watt had done a carefully controlled investigation on 24 chronic schizophrenics, alternating chlorpromazine, placebo and reserpine, and came to the conclusion that only chlorpromazine was therapeutically effective in his series. The comparatively small number of cases treated and the short periods of time (six weeks) during which patients were kept on each drug must be considered in finally evaluating his results.

Rees observed that patients who in the Funkenstein test could be classified in groups 1, 2 or 6, i.e. those who reacted strongly to adrenaline or mecholyl, had a better prognosis with chlorpromazine, while Ey *et al.* noted that schizophrenic patients with discontinuous alpha rhythm in their electroencephalogram responded less favourably than those with continuous alpha rhythm. Bonnet observed that patients with a high threshold to photic driving and photomyoclonic response react better than those with a low threshold.

A number of reports dealt with the use of chlorpromazine in epilepsy. The drug seems to lower the convulsive threshold and thus increase the tendency to seizures. However, in combination with barbiturates or other anticonvulsant drugs chlorpromazine often proves useful in myoclonic epilepsy and in behaviour disorders associated with epilepsy. Delgado reported on clinical experience with the drug in Peru, and Falcon on its psychiatric use in Mexico.

Bleuler suggested guides for the therapeutic application of chlorpromazine and reserpine. While chlorpromazine is faster acting than reserpine, he feels that it is relatively contraindicated in patients with suspected liver damage. Reserpine, on the other hand, is in his opinion contraindicated in cases in which extrapyramidal damage or stomach disturbances are suspected.

Overholser pointed to the changes that may be brought about in mental hospitals by the new drugs. Mayer-Gross discussed the possibilities of future pharmacological discoveries in psychiatry and stressed the need for carefully controlled studies. Hoff warned against over-enthusiastic neglect of other physical treatments and emphasized the